CHANGE OF AGE: Film G94 4-18-45 L (CAC)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02400

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Lal Vale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? a few minutes
Hospital, institution, or street address where death occurred: Near Cumberland, Rural
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Ellerslie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Dwight Eldin Airesman

3.(b) Social Security Number: 218-16-4209

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 2, 1923

8. AGE: Years 21 7/12 | Months 5 | Days 13 7/12 | If less than one day: hrs. min.

9. Birthplace: Listie Pa (Town, county, and state)

10. Usual occupation: Laborer - Trackman

11. Industry or business: Balto. and Ohio R.R. Co.

FATHER 12. Name: Harry Airesman

13. Birthplace: Pa

MOTHER 14. Maiden name: Mary Grace Shaffer

15. Birthplace: Pa

18. Informant: Mrs. Mary Airesman
Address: Ellerslie, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 18 1945 (month) (day) (year)
Cemetery or crematory: Pleasant Hill
Location: Somerset, R.D. Pa.

18. Funeral director: Harvey H. Leigler
Address: Hyndman, Pa

19. Mar 17, 1945 (Date rec'd by registrar) Walter R. Trauth M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15th., 1945, at 5:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Pierce H. Brant, M. D.
M. D. or other
Address: Cumberland, Maryland Date signed: 3-15-45

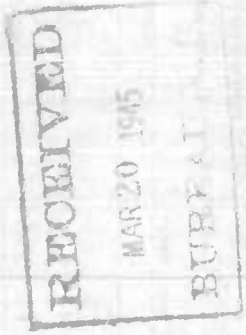
County Medical Examiner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

AUTH. IN GENERAL FILE under AIRESMAN 4-18-45 L



Evidence for change of age of deceased is shown on FILM No. G 9 4 MAY 15 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22nd)

CERTIFICATE OF DEATH

02401

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution or street address where death occurred: 717 Grand Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 717 Grand Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bessie Biser Alderton

3.(b) Social Security Number 705-09-9694

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Jesse Beatrice Powell

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 11 1900

8. AGE: Years	Months	Days	If less than one day
44 40-	10	1	____ hrs. ____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business B & O Ry.

FATHER 12. Name Frank Alderton

13. Birthplace Md.

MOTHER 14. Maiden name Lavina Kifer

15. Birthplace Md.

16. Informant Mrs. H. L. Hoyle

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13 '45 (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. March 13 19 45 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1945 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb'y 14 to March 10 1945

and that I last saw h alive on March 10 1945

Immediate cause of death	DURATION
Coronary Thrombosis	20 yrs
Due to Heart Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. S. Lawrence M.D. or other

Address 332 Va Ave Date signed 3/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. C.L. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02402

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Hampshire
City or town: Romney
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: /

3.(a) FULL NAME: Frederick W. Allen, Jr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11, 1944

8. AGE: Years	Months	Days	If less than one day
	8	20	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Infant
11. Industry or business:

FATHER
12. Name: Frederick W. Allen
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Marjorie Wolford
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial - (Burial, cremation, or removal. Which?) Date thereof 3-3-45 (month) (day) (year)
Cemetery or crematory: Indian Mound.
Location: Romney.

18. Funeral director: Thresh's.
Address: Romney. W. Va.

19. Mar. 3, 1945 (Date rec'd by registrar) Winter R. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1945 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 24 1945 to March 1 1945 and that I last saw him alive on March 1 1945

Immediate cause of death	DURATION
Pneumococcic Pneumonitis	3 wks
Due to: non contagious	
Other conditions: Bronchio Pneumonia	1 wk

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. L. Owens M.D. M. D. or other
Address: Romney Hardy Co. W. Va. Date signed 3-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02403

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 Years

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 525. Fayette St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Amelia Bareis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Whits	Married

6.(b) Name of husband or wife: Peter Bareis

6.(c) If alive, give age: 84 years

7. Birth date of deceased (mo., day, yr.): July 6 1870

8. AGE: Years	Months	Days	If less than one day
74	8	18	...hrs. ...min.

9. Birthplace: Cumberland, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER — 12. Name: Francis C Reichert

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Teresa Wertman

MOTHER — 15. Birthplace: Germany

18. Informant: Francis L Bareis

Address: 525. Fayette St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/45 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: Willian H. Kight

Address: Cumberland, Md.

19. Mar. 27 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1945, at 6:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1945, to March 25 1945

and that I last saw h.. alive on March 25 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L B Matthews M.D. M. D. or other

Address: 49 Greene St Date signed: 3-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1044)

02404

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred: 633 Yale St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 633 Yale St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Gary Evan Barnes

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 13, 1944

8. AGE: Years ~ | Months 8 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Elroy H. Barnes
13. Birthplace: Oldtown, Md.

MOTHER
14. Maiden name: Amelia E. Brinkman
15. Birthplace: Cumberland, Md.

16. Informant: Elroy H. Barnes
Address: 633 Yale St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 31, 1945 (month) (day) (year)
Cemetery or crematory: Three Churches Methodist Cemetery
Location: Three Churches, W. Va.

18. Funeral director: John J. Hafer
Address: Cumberland, Md.

19. Mar. 31 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1945, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1945 to March 30 1945
and that I last saw h[illegible] alive on March 30 1945

Immediate cause of death	DURATION
Pneumonia	2 days
Due to	
Due to	
Diher conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: M.B. Owens M. D. or Other
Address: 33 Va Ave Date signed: 3/30/45

M. E. B. Owens

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

02405

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Alleghany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Alleghany
City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Baby Blubaugh

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March 23, 45

8. AGE:

Years	Months	Days	If less than one day
–	–	–	17 hrs. ... min.

9. Birthplace: Cumberland, Md (Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Harry C Blubaugh
13. Birthplace: Gilmore, Md

MOTHER
14. Maiden name: Hannah Ewing
15. Birthplace: Frostburg, Md

16. Informant: Harry C Blubaugh
Address: Cresaptown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 24 45 (month) (day) (year)
Cemetery or crematory: Old County Cemetery
Location: Lonaconing Md
18. Funeral director: W. E. Calhoun
Address: Lonaconing Md
19. Mar 23 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-23 1945, at 9 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-23 1945, to 3-23 1945
and that I last saw h[illegible] alive on 3-23 1945

	DURATION
Immediate cause of death: premature baby (7 months)	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W Bruns MD
M. D. or other
Address: Ley Md Date signed 3-25-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (116-P)

02406

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:

County: Alleg.

City or town: Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred: Orchard St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md County: Alleg.

City or town: Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Orchard St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Rennie Bolan

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Albert Bolan

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 5 1863

8. AGE:

Years	Months	Days	If less than one day
81	10	25	..... hrs. ..... min.

9. Birthplace: Harford Co Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Charles Harris

13. Birthplace: md.

MOTHER — 14. Maiden name: Mary Micheal

15. Birthplace: md

16. Informant: Mrs James Raley

Address: Ellerslie Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 2 1945 (month) (day) (year)

Cemetery or crematory: Bradley Church Yard

Location: Bradley, Pa.

18. Funeral director: Louis J Stein Jr

Address: Cumberland md

19. April 31 1945 (Date rec'd by registrar) J Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1945, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1945, to March 30 1945 and that I last saw h[illegible] alive on March 30 1945

Immediate cause of death: Carcinoma Stomach. — DURATION: 2-years

Due to:

Due to:

Other conditions: Old age - Secondary anemia.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: William E. Moseley M.D.

M. D. or other

Address: Mt Savage md. Date signed: 3/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24a)

02407

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH:

County: Allegany

City or town: Cresaptown (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Hours

Hospital, institution, or street address where death occurred:
Celenase Corp (Plant)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10. Independence St
(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 1.

3.(a) FULL NAME: John Francis Boyle

3.(b) Social Security Number: 214-07-2006

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 10 1887

8. AGE: Years	Months	Days	If less than one day
57	10	5	hrs. min.

9. Birthplace: Scotland
(Town, county, and state)

10. Usual occupation: Dye House Employee

11. Industry or business: Celenese Corporation

FATHER
12. Name: Peter J. Boyle
13. Birthplace: Scotland

MOTHER
14. Maiden name: Mary Toner
15. Birthplace: Scotland

16. Informant: Mrs. Terrance Boyle
Address: 10. Independence St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/19/45 (month) (day) (year)

Cemetery or crematory: St. Patricks Cemetery

Location: Mt. Savage, Md.

18. Funeral director: Willian H. Kight

Address: Cumberland, Md.

19. 4/17 (Date rec'd by registrar) 19 45 M.G. Dennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15th., 19 45, at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Pierce H. Bolton M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 3-15-45

Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

02408

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 yrs.

Hospital, institution, or street address where death occurred: 534 Maryland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 534 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Margaret Brown

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Edward Brown.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 26, 1854

8. AGE: Years: 90 Months: 10 Days: 6 If less than one day: ..... hrs. ..... min.

9. Birthplace: Montour Pa (Town, county, and state)

10. Usual occupation: Housemaid

11. Industry or business:

FATHER 12. Name: John Beaton

13. Birthplace: Ireland

MOTHER 14. Maiden name: Ann Mc Dohd.

15. Birthplace: Ireland

16. Informant: Mrs Mrs Anna Mc Connell

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 3 45 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland, Md.

LOUIS STEIN, INC.

18. Funeral director: FUNERAL DIRECTORS

Address: Cumberland

19. Mar 3 19 45 (Date rec'd by registrar) Winter L. Hauptly M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 19 45, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 45 to Mar 1 45

and that I last saw h... alive on 2 - 13 19 45

Immediate cause of death	DURATION
Chronic myocarditis	5 yrs
Due to	
Due to	
Other conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: R. H. Saunders M.D. M. D. or other

Address: Cumberland Md Date signed 3/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02409

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Rural Cumberland - Baumans Addt.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Baumans Addt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Baumans Addt.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Walter Bunner

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 14, 1945

8. AGE: Years	Months	Days	If less than one day
0	0	3	...hrs. ...min.

9. Birthplace Cumberland Allegany, Md.
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name John W. Bunner
13. Birthplace Red Creek, W. Va.

MOTHER
14. Maiden name Floreana Whetzel
15. Birthplace Petersburg, W. Va.

16. Informant John W. Bunner
Address Baumans Addt.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 19 1945 (month) (day) (year)

Cemetery or crematory Philos Cemetery

Location Westernport, Md.

18. Funeral director John F. Hofer

Address Cumberland, Md

19. March 19, 1945 (Date rec'd by registrar) Walter R. Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1945, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 1945 to March 17 1945 and that I last saw him alive on March 17 1945

Immediate cause of death	DURATION
Bunnia	2 hrs.
Anaemia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Cumberland Md Date signed March 19, 1945

Dr. Murray

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-L)

02410

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 Years

Hospital, institution, or street address where death occurred: 10. Decatur St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10. Decatur St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Frank Lee Carl

3.(b) Social Security Number: 220-03-7759

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Carl

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): May 11 1871

8. AGE: Years	Months	Days	If less than one day
73	10	9	...hrs. ...min.

9. Birthplace: Hancock, Washington Co, Maryland (Town, county, and state)

10. Usual occupation: Editor

11. Industry or business: Cumberland Evening Times

FATHER — 12. Name: Adam A. Carl

13. Birthplace: Hancock, Md.

MOTHER — 14. Maiden name: Annie Sprenkle

15. Birthplace: Lebannon Pa

16. Informant: Mrs. Frank Lee Carl

Address: 10. Decatur St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/22/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Mar. 22, 1945 (Date rec'd by registrar) Walter L. Featy, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 1945, at 5:15 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1944, to March 20 1945 and that I last saw h... alive on March 19 1945

Immediate cause of death	DURATION
Pneumonia	10 days
Due to: Chron. Nephritis	1 year
Due to:	
Other conditions: Carcinoma of R Tonsil	1 year
Head & Neck	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Adam E. Mason M.D. M. D. or other

Address: Cumberland, Md. Date signed: March 21 45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

02411

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20. Years

Hospital, Institution, or Street address where death occurred:
Rt # 2. Baltimore Pike

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt # 2. Baltimore Pike
(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 1.

3.(a) FULL NAME: Marshall Hayes Clingerman

3.(b) Social Security Number: 214-058-438

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rhoda Clingerman

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): October 24, 1894

8. AGE: Years	Months	Days	If less than one day
50	4	11	...hrs. ...min.

9. Birthplace: Artemas, Pa. Bedford County
(Town, county, and state)

10. Usual occupation: Service Statain

11. Industry or business: Gasoline

FATHER
12. Name: John Clingerman
13. Birthplace: Artemas, Pa

MOTHER
14. Maiden name: Margaret Crawford
15. Birthplace: Artemas, Pa.

16. Informant: Mrs. M. H. Clingerman
Address: Rt # 2, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 8, 1945 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery

Location: Artemas, Pa.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Mar. 7 (Date rec'd by registrar) 19 45 Walter R. Brantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5th., 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above steted; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Bruce H. Brown M.D. M. D. or other

Address: Cumberland, Maryland. Date signed: 3-6-45

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

02412

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: 223 Pennsylvania Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 223 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mae E Corrick

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Eddie Corrick

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day hrs. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles Orr Kinzie

13. Birthplace Md.

MOTHER 14. Maiden name Ellen Blair

15. Birthplace Md.

16. Informant Ed. Corrick

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 17 45 (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. March 16, 1945 (Date rec'd by registrar) Walter L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945 at 5-50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 5 1945 to Mar. 14 1945 and that I last saw her alive on Mar. 13 1945.

Immediate cause of death	DURATION
Arteriosclerosis	5 yrs
Hypostatic	2 yrs
Due to Coronary Thrombosis	days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clayton L. Jones M. D. or other

Address Cumberland Date signed 3-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

02413

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Fort Cumberland Hotel
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Frank Darby

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 4. 1871

8. AGE: Years	Months	Days	If less than one day
74	1	26	..... hrs. ..... min.

9. Birthplace: Fort Mott, South Carolina
(Town, county, and state)

10. Usual occupation: Freight Agent

11. Industry or business: Railroad. W.M.R.R.

FATHER
12. Name: Jefferson Darby
13. Birthplace: S.C.

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: J. B. Darby
Address: Cranford, New Jersey

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3 1945 (month) (day) (year)

Cemetery or crematory: Cranford Cemetary

Location: Cranford. N.J.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. April 1, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1945, at 9:47P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-27-45 to 3-30-45

and that I last saw him alive on 3-30-45

Immediate cause of death	DURATION
Acute myocarditis	6 days
Due to Bronchial Pneumonia; Cause.	
Due to	
Other conditions Hypostatic Pneumonia	2 days
Arteriosclerosis; several months.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed 3-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

02414

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs.

Hospital, institution, or street address where death occurred: 511 Maryland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 511 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rachel Francis DeVore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Paul L. DeVore

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) June 20, 1899

8. AGE: Years 45 | Months 9 | Days 1 | If less than one day ... hrs. ... min.

9. Birthplace Midland Alleg. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Louis Knickerbocker

13. Birthplace Ellerslie Pa.

MOTHER 14. Maiden name Susanne Retalick

15. Birthplace England

16. Informant Paul L. DeVore

Address Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 23 1945 (month) (day) (year)

Cemetery or crematory Philos

Location Westernport Md.

18. Funeral director Mrs. Ray Boal Berry

Address Westernport, Md.

19. Mar. 22 19 45 (Date rec'd by registrar) J. Raymond Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1945 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1945 to March 21 1945 and that I last saw h.. alive on March 21 1945

	DURATION
Immediate cause of death: Cardio Vascular renal disease	6 mo
Cerebral apoplexy	1 day
Due to:	
Due to:	
Other conditions: Hypertension	6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Norman Reever M.D. M. D. or other

Address Westernport, Md. Date signed 3-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02415

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, Institution, or street address where death occurred: 108 Springdale St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 108 Springdale St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Hayes Dibert

3.(b) Social Security Number: 220-07-6199

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ursye Roland
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 19 1899

8. AGE: Years 45 | Months 7 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Celanese employee
11. Industry or business
FATHER 12. Name: Wm H. Dibert
13. Birthplace: Pa.
MOTHER 14. Maiden name: Susanna Dean
15. Birthplace: Md.
16. Informant: Mrs Wm H. Dibert
Address: Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/18/45 (month) (day) (year)
Cemetery or crematory: Dist Herman Cem.
Location: Cumberland.
18. Funeral director: Louis Stein Inc
Address: Cumberland.
19. Mar 17 1945 (Date rec'd by registrar) Winter R Frantz M.D. Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: March 14th, 1945, at 8 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronery Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Lewis H. Dotson, M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 3-15-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-c)

CERTIFICATE OF DEATH

02416

02416

Reg. Diat. No. 6

1. PLACE OF DEATH:

County Alleg.

City or town Near Westernport Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Alleg.

City or town Mc Coole Rd. Near Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rollena L. Barnard Duckworth

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Americus Duckworth

6.(c) If alive, give age ..... years

7. Birth date of decoesed (mo., day, yr.) Oct. 10. 1865

8. AGE: Years 79 | Months 4 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Near Shaft Alleg Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business Own Home

FATHER 12. Name Nathaniel Barnard

13. Birthplace Not Known

MOTHER 14. Maiden name Nancy C. Sears

15. Birthplace Pa.

16. Informant Mrs. Mary Duckworth

Address Mc Coole Road Near Westernport

17. Burial (Burial, cremation, or removal, Which?) Date thereof March 8 1945 (month) (day) (year)

Cemetery or crematory Philos

Location Westernport, Md.

18. Funeral director Mrs. Fay Boal Berry

Address Westernport Md.

19. Mar. 8 (Date rec'd by registrar) 1945 G. Grayson Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-4 1945, to 3-5- 1945 and that I last saw her alive on 3-5- 1945

Immediate cause of death	DURATION
Chronic Myocarditis.	
Duration 1 Unknown.	
Due to Rheumatism. Q.U.G.R.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jno A. Newcomer M.D.
M. D. or other

Address Keyser W. Va. Date signed 3-7-45

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-0

CERTIFICATE OF DEATH

02417

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Susan E. Durst

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: Winfield S. Durst
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 16 - 1856

8. AGE: Years	Months	Days	If less than one day
88	10	28	..... hrs. ..... min.

9. Birthplace: Ashton - Garrett Co. - Md.
(Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business

FATHER
12. Name: Isaac Crowe
13. Birthplace: Md

MOTHER
14. Maiden name: Mary E. Chaney
15. Birthplace: Md

16. Informant: Isaac W Crowe
Address: Cumberland Md. Route 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 17-1945 (month) (day) (year)
Cemetery or ~~crematory~~: Bloomington
Location: Garrett Co.
18. Funeral director: J. J. Durst
Address: Frostburg Md

19. 3-17 (Date rec'd by registrar) 1945 Mrs. Haney H. Ross Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1945, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1945, to March 13, 1945 and that I last saw h[illegible] alive on March 13 1945

Immediate cause of death: Heart attack	DURATION
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Dr. W. E. Gattens - B. Wellas assistant M. D. or other
Address: 167 E. Main St. Date signed: 3/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Williams
Evidence for change of year of birth of deceased is shown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

02418

FILM No. G 9 4 MAY 15 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGHENY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNSYLVANIA County BEDFORD CO.
City or town EVERETT
(If outside city or town limits, write RURAL and give nearest town)
Street No. 147 EAST MAIN ST.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME MRS. SARAH EICHELBERGER

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife FRANK EICHELBERGER
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) OCTOBER 22, 1868

8. AGE: Years	Months	Days	If less than one day
76	4	14	hrs. min.

9. Birthplace EVERETT, PENNSYLVANIA, BEDFORD (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name DAVID DEFFINBAUGH
13. Birthplace PENNSYLVANIA
MOTHER 14. Maiden name SUSAN, BELT
15. Birthplace PENNSYLVANIA
16. Interment MEMORIAL HOSPITAL CUMBERLAND
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 8, 1945 (month) (day) (year)
Cemetery or crematory EVERETT
Location EVERETT, PA
18. Funeral director D. S. Lamb AND SON By J.R.M.
Address EVERETT, PA.
19. May. 6, 1945 (Date rec'd by registrar) Wirley R. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 6, 1945 19..... at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3.3.1945 to 3.6.1945 and that I last saw h.er alive on 3-5-1945

Immediate cause of death	DURATION
Chronic Hypertension	
Due to Valvular Heart Disease	
Due to Chronic Myocardial Degeneration	
Other conditions Bronchio Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. F. Williams M. D. or other
Address Cumberland Md. Date signed 3.6.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

02419

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Bedford

City or town: Hyndman

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Barbara Lewis Elliott

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Milton Elliott B.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.): May 10, 1875.

8. AGE:

Years	Months	Days	If less than one day
69	10	3	hrs. min.

9. Birthplace: Artemas, Bedford, Pa (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Bartley Smith

13. Birthplace: Penna.

MOTHER 14. Maiden name: Sarah Twigfield

15. Birthplace: Penna.

16. Informant: Sheridan Lewis

Address: Buffalo Mills, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 16, 1945 (month) (day) (year)

Cemetery or crematory: Greenlawn

Location: Roaring Springs, Pa

18. Funeral director: Harvey D. Weigle

Address: Hyndman, Pa.

19. March 16, 1945 (Date rec'd by registrar) Walter R. Trauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1945, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to Mar. 13 1945

and that I last saw h.er alive on Mar. 12 1945

Immediate cause of death: Diabetes Mellitus — DURATION 5 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John A Topper 2nd M. D. or other

Address: Hyndman Pa Date signed 3/14/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. TOPPER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

CERTIFICATE OF DEATH

02420

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Bedford
City or town: Hyndman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: Mr. Benjamin E. Emerick

3.(b) Social Security Number: 705-10-7827

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mabel Poorbaugh
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): January 28, 1894

8. AGE: Years	Months	Days	If less than one day
51	1	7	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Telegraph Operator
11. Industry or business: B & O Railroad

FATHER
12. Name: Benjamin Emerick
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Sarah Riley
15. Birthplace: North Carolina

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 8, 1945 (month) (day) (year)
Cemetery or crematory: Hyndman
Location: Hyndman, Pa.

18. Funeral director: Harvey H. Feigley
Address: Hyndman, Pa.

19. Mar. 7, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1945, at 6:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1944 to March 5 1945
and that I last saw h... alive on March 5 1945

Immediate cause of death	DURATION
Carcinoma of Rt. Lung	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John A Topper MD M. D. or other
Address: Hyndman Pa Date signed 3/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

02421

2411 N. Charles St., Baltimore (170-c)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: Main Street (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: John Harley Evans

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Child

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov 28, 1942.

8. AGE: Years	Months	Days	If less than one day
2	3	7	...hrs. ...min.

9. Birthplace: Cumberland Allegany Co. Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER — 12. Name: John H. Evans

FATHER — 13. Birthplace: Lonaconing Md.

MOTHER — 14. Maiden name: Margaret Yates

MOTHER — 15. Birthplace: Moscow Pa.

16. Informant: John H. Evans

Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7 1945 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Moscow, Pa.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. 3-8 (Date rec'd by registrar) (45 Mrs. Nancy H. Ross) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5th., 19 45, at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Pulmonary Embolism	6 hrs.
(following traumatism)	40 min.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: casts applied — Date of op.: —

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident — Date of: 3-5-45.

Where did injury occur? Lonaconing, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: struck by truck — Injured at work? no

23. SIGNATURE: Prince H. Dotson M.D. (M. D. or other)

Address: Cumberland, Maryland — Date signed: 3-6-45

Deputy Medical Examiner - Allegany Co.

(M) (1) (2)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02422

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 714 Elm St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Georgie Ann Fields.

3.(b) Social Security Number None.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Howard E. Fields.

6.(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) May 9 1900

8. AGE: Years	Months	Days	If less than one day
44	10	—	...hrs. ...min.

8. Birthplace Clarksburg W. Va.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home.

FATHER

12. Name John Bashore.

13. Birthplace W. Va.

MOTHER

14. Maiden name — Bashore

15. Birthplace Md.

16. Informant Howard E Fields

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 12 45 (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland.

18. Funeral director Lonis Stein Inc.

Address Cumberland

19. Mar. 12, 1945 (Date rec'd by registrar) Walter L Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 1945 at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 1944 to Mar. 9. 1945 and that I last saw h... alive on Mar. 9. 1945

	DURATION
Immediate cause of death Coma	2 yrs.
Due to Myocarditis	3 mon.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Jarrett M. D. or other

Address Cumberland Date signed 3/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

02423

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31. Years

Hospital, institution, or street address where death occurred:
Rt #1, Klostermans Addition

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City: Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt #1, Klostermans Addition
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Abner William Fishell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary Fishell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 29 1868

8. AGE: Years	Months	Days	If less than one day
76	11	22	..... hrs. ..... min.

9. Birthplace: Frederick Co, Virginia
(Town, county, and state)

10. Usual occupation: Retired Glass Employe

11. Industry or business: Wellington Glass Works

FATHER
12. Name: Issac Fishell
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: John Fishell
Address: Rt # 1, Box 321, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/23/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Mar 23, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1945 at 9 10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1945 to March 21 1945 and that I last saw him alive on March 21 1945

Immediate cause of death	DURATION
Cardiac Renal	
Due to: Age + Arterio Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E Keeler M. D. or other

Address: 122 Bedford St Date signed: 3/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31+c)

02424

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days.

Hospital, Institution, or street address where death occurred: 129 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 129 Greene St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Adrian K. Flora.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Emma Cooper.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 23 1871

8. AGE: Years	Months	Days	If less than one day
73	2	18	..... hrs. ..... min.

9. Birthplace Magnolia W. Va.

(Town, county, and state)

10. Usual occupation Minister

11. Industry or business

FATHER 12. Name Jasper Wm. Flora

13. Birthplace West Virginia

MOTHER 14. Maiden name Mary Elizabeth

15. Birthplace West Virginia

16. Informant Emma C. Flora

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 14, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland, Md.

18. Funeral director Davis Stein, Inc

Address Cumberland, Md.

19 March 14, 1945 Winter L. Tranty, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1943, to March 11 1945 and that I last saw him alive on March 11 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. D. Matthews, M.D. M. D. or other

Address 49 Greene St Date signed 3-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7-d)

CERTIFICATE OF DEATH

02425

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address (where death occurred): 236 Main St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 236 Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME David Gift

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Cora Watring Gift

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 22 1862

8. AGE: Years	Months	Days	If less than one day
82	11	16	hrs. min.

9. Birthplace: Franklin Pa.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: W.P.A.

FATHER — 12. Name: A. James Gift

FATHER — 13. Birthplace: Not known

MOTHER — 14. Maiden name: Not known

MOTHER — 15. Birthplace:

16. Informant: Wayne Gift

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 0 1945 (month) (day) (year)

Cemetery or crematory: Chives

Location: Westernport, Md.

18. Funeral director: Mrs. Day Boal Berry

Address: Westernport, Md.

19. March 9 19 45 (Date rec'd by registrar) A. Grayson Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 19 45 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 44 to March 8 19 45 and that I last saw him alive on March 8 19 45

Immediate cause of death	DURATION
Myocarditis	2 yrs.
Due to	
Due to	
Other conditions: Nose Bleed	3 wks.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. E. Berry M.D.
M. D. or other

Address: Piedmont, W.Va. Date signed: 3/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 415

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02426

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred: 214 Glenn St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 214 Glenn St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Leroy Goodrich

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Bertha Porter

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1865

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	5	27		

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Engineer Ry.

11. Industry or business Retired

FATHER 12. Name Roe D. Goodrich

FATHER 13. Birthplace Ind.

MOTHER 14. Maiden name — Homan

MOTHER 15. Birthplace Pa.

16. Informant Stanley W. Goodrich

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 6 45 (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland

18. Funeral director Louis Stein Sons

Address Cumberland

19. March 6 1945 (Date rec'd by registrar) Walter L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1943 to December 3 1945 and that I last saw him alive on 2/15/45 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K. Green M.D.

M. D. or other

Address Cumberland Date signed 3/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A 16-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02427

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 108 Karns Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Karns Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mathilda Hamilton

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	W.

B.(b) Name of husband or wife Harvey Hamilton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 31 1878

8. AGE: Years	Months	Days	If less than one day
66	6	30	..... hrs. ..... min.

9. Birthplace Cumberland, Allegany, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Christopher Nutt

13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Bernadine Rebe

15. Birthplace Germany

16. Informant John H. Hamilton

Address 108 Karns Ave. Comberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2 1945 (month) (day) (year)

Cemetery or crematory St Peter & Paul Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. April 1, 1945 (Date rec'd by registrar) Winter R. Mauntz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945, at 6.40 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 30 1945 to March 30 1945

and that I last saw her alive on March 30 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE D Kepler M. D. or other

Address 122 Bedford St Date signed 3/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

02428

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 yrs

Hospital, institution, or street address where death occurred: 82 Broadway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 82 Broadway

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Vansa

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Ulysses Vansa

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 2nd 1869

8. AGE:

Years	Months	Days	If less than one day
75	3	12	hrs. min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Daniel Gallagher

FATHER — 13. Birthplace: South Wales

MOTHER — 14. Maiden name: Emma Perry

MOTHER — 15. Birthplace: England

16. Informant: Mrs. Wm. Welsh

Address: 82 Broadway

17. Burial, cremation, or removal: Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 16 1945 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: Jacob J. Baker

Address: Frostburg, Md.

19. 3-16 1945 Mrs. Hawley H. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1945, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/11 1945, to 3/13 1945

and that I last saw h... alive on 3/13 1945

Immediate cause of death	DURATION
Coronary Thrombosis	48 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hilda Jane Walton, M.D. M. D. or other

Address: Frostburg Md Date signed: 3/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1942)

CERTIFICATE OF DEATH

02429

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Morgan
City or town: Great Cacapon
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Bernard Harden

3. (b) Social Security Number: 212-10-8543

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Pearl Harden
6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): April 11 1906

8. AGE: Years	Months	Days	If less than one day
38	11	15	...hrs. ...min.

9. Birthplace: Great Cacapon, Morgan Co., W. Va.
(Town, county, and state)
10. Usual occupation: Trackman
11. Industry or business: B&ORR

FATHER
12. Name: William M. Harden
13. Birthplace: Great Cacapon, W. Va.

MOTHER
14. Maiden name: Leota V. Dyche
15. Birthplace: Great Cacapon, W. Va.

16. Informant: Mrs. Bernard Harden
Address: Great Cacapon, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/29/45 (month) (day) (year)
Cemetery or crematory: Nebo Cemetery
Location: Orbeans, W. Va.

18. Funeral director: W. D. Parks
Address: Berkeley Springs, W. Va.

19. Mar. 29 1945 (Date rec'd by registrar) Winter K. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 27 1945 at 12 30 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 23 1945 to Mar 27 1945 and that I last saw him alive on Mar 26 1945

Immediate cause of death	DURATION
Chronic Nephritis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: R. A. Speraskis M.D. M. D. or other
Address: Cumberland, Md Date signed 3/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (148a)

CERTIFICATE OF DEATH

02430

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 823 LaFayette Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Edith (Hardy) Hare

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas Hare
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1924

8. AGE: Years	Months	Days	If less than one day
21	0	26	hrs. min.

9. Birthplace: W. Va. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Ralph Hardy
13. Birthplace: ~~W. Va.~~ Cumberland, Md.

MOTHER
14. Maiden name: Bertie Grimes
15. Birthplace: Lonaconing, Md.

16. Informant: Mr. Thomas Hare
Address: 823 Lafayette Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 26, 1945 (month) (day) (year)
Cemetery or crematory: Zion Memorial Cem.
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Mar. 26, 1945 (Date rec'd by registrar) Wilbur R. Beanty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/23/45, 19..., at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 8, 19..., to March 23, 19..., and that I last saw her alive on March 23, 19...

	DURATION
Immediate cause of death: Toxemia of Pregnancy.	2 weeks
Due to: Puerperal Eclampsia.	1 day
Due to: Child born March 22nd, 1945, in Cumberland.	
Due to: with Pulmonary Oedema.	1/2 day
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. R. Beanty M. D. M. D. or other
Address: 132 Va Ave Date signed: 3/24/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

CERTIFICATE OF DEATH

02431

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred: 1601 Ford Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1601 Ford Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Edward Ronald Hare

3.(b) Social Security Number None

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.) Sept 22, 1944
8. AGE: Years 0 Months 6 Days 8 If less than one day ....hrs. ....min.
9. Birthplace Cumberland Allegany Co, Md.
(Town, county, and state)
10. Usual occupation Infant
11. Industry or business
FATHER
12. Name James E. Hare
13. Birthplace Cumberland, Md.
MOTHER
14. Maiden name Opal Wolford
15. Birthplace Higginsville, W. Va.
16. Informant James E. Hare
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 1, 1945 (month) (day) (year)
Cemetery or crematory Zion Memorial
Location Cumberland
18. Funeral director Foley J. Hofer
Address Cumberland
19. Mar. 31, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 1945, at 3:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 1945, to March 30 1945
and that I last saw her alive on March 29 1945

Immediate cause of death Pneumonia bronchial — DURATION 3 days
Due to Whooping Cough — 3 weeks
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. E. B. Owens M. D. or other
Address 133 Va. Ave. Date signed 3/31/45

M. E. B. Owens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-1)

CERTIFICATE OF DEATH

02432

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Luke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Luke

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pratt

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mildred Elizabeth Hastis

3. (b) Social Security Number: 216-01-3076

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1911

8. AGE: Years: 34 | Months: 1 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: Luke Alleg Md. (Town, county, and state)

10. Usual occupation: Buyer

11. Industry or business: Clothing store

FATHER — 12. Name: Charles E. Hastis

FATHER — 13. Birthplace: Wilmington, Delaware

MOTHER — 14. Maiden name: Clemtra Greenhorn

MOTHER — 15. Birthplace: Longacoming Md.

16. Informant: Mrs. Charles E. Hastis

Address: Luke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 6 1945 (month) (day) (year)

Cemetery or crematory: Phillips

Location: Westernport Md.

18. Funeral director: Mrs. Mary Beal Keary

Address: Westernport, Md.

19. March 6 1945 (Date rec'd by registrar) A. Jay Nesbit M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1945 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 6 1944 to Mar 3 1945

and that I last saw h alive on Mch 3rd 1945

Immediate cause of death	DURATION
Primary carcinoma of rectum	2 years
Due to Carcinoma of Breast	1 yr
Due to Kyphosis	
Other conditions Carcinoma of liver	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: David H. Stuart M.D. M. D. or Coroner

Address: Piedmont Date signed 3-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02433

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 yrs

Hospital, institution, or street address where death occurred: 751 N. Mechanic

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 251 N. Mechanic St.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War

3.(a) FULL NAME

Frank Himmler

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Divorced

6.(b) Name of husband or wife: Edna Jones (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 1st 1890

8. AGE: Years	Months	Days	If less than one day
54	3	16	hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Unable to work

11. Industry or business

FATHER — 12. Name: Henry Himmler

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Leopoldina Fellinger

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs Lloyd Eckenrode

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 1 45 (month) (day) (year)

Cemetery or crematory: St Lukes Cem

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. April 1, 1945 (Date rec'd by registrar) Winter R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-30 1945, at 7:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 1945 to March 30 1945 and that I last saw h... alive on March 28 1945

	DURATION
Immediate cause of death: pulmonary tuberculosis	Many years
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W Bruce M.D.
M. D. or other

Address: Lonaconing Md Date signed: 3-30-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

02434

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #1, Box 88
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Lee Hinkle

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 11, 1865

8. AGE: Years	Months	Days	If less than one day
79	3	20	hrs. min.

9. Birthplace: Maryland Allegany Co.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Leonard Hinkle
13. Birthplace: Maryland

MOTHER
14. Maiden name: Catherine McElfish
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 3, 1945 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland, Md.

18. Funeral director: John J. Hafer
Address: Cumberland Md.

19. April 3 1945 (Date rec'd by registrar) Wintes R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-18- 1945, to 3-31- 1945
and that I last saw h.i.m. alive on 3-31- 1945

Immediate cause of death: Myocardial Degeneration Arteriosclerosis — DURATION

Due to:

Due to:

Other condition: Benign hypertrophy prostate
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op. 3-26-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard L. Folson, Md.
M. D. or other
Address: Cumberland Md. Date signed: 3-31-45

MARYLAND STATE DEPARTMENT OF HEALTH

02435

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

County Allegany

City or town Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Alleg. 10

City or town Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary A. Houck

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widow

6.(b) Name of husband or wife Daniel Houck

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1854

8. AGE: Years 90 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Frostburg Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Reuben Anthony

13. Birthplace —

MOTHER 14. Maiden name Ann Llewellyn

15. Birthplace —

16. Informant Miss Maud Houck

Address Mt Savage Md

17. Burial Date thereof May 31 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland Md

18. Funeral director Louis Stein Sons

Address Cumberland Md

19. 3-30- 1945 Dennison W Demuth

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 1945, at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945, to March 28 1945

and that I last saw h alive on March 28 1945

Immediate cause of death Myocarditis 8

Mitral regurgitation

Due to Old age -

Due to

Other conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

DURATION
Several years -
?

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Moseley M.D.

M. D. or other

Address Mt Savage Md. Date signed 3-29-1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02436

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 638 Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Miss Mary M Hudson

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 8 1873

8. AGE: Years	Months	Days	If less than one day
72	1	16	..... hrs. ..... min.

9. Birthplace: W. Va. Williamsport
(Town, county, and state)

10. Usual occupation: Registered Nurse

11. Industry or business: Nursing Sick

FATHER
12. Name: Thomas Hudson
13. Birthplace: Culpepper, Va.

MOTHER
14. Maiden name: Martha Fulk
15. Birthplace: Broadway, Va.

16. Informant: Mrs Agnes R. Grimes
Address: 638 Washington St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/27/45 (month) (day) (year)
Cemetery or crematory: Hill Crest Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Mar 27 1945 (Date rec'd by registrar) Walter P. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24, 1945, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 24 1945 to March 24 1945 and that I last saw h- alive on March 24, 1945

Immediate cause of death	DURATION
Uremia Coma	
Due to Myocarditis -	3 hrs
Due to nephritis -	many yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thos R Hudson M. D. or other

Address: Cumberland Md Date signed: 3/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

02437

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 430 S. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Henry Christopher Hyde

3. (b) Social Security Number: 212-18-1807

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Theodosia Kuhns

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug 17 1859

8. AGE: Years: 85 Months: 7 Days: 9 If less than one day: ... hrs. ... min.

9. Birthplace: Alexandria Va. (Town, county, and state)

10. Usual occupation: Wool Grader

11. Industry or business:

FATHER — 12. Name: Christopher Hyde

FATHER — 13. Birthplace: Va.

MOTHER — 14. Maiden name: Unknown.

MOTHER — 15. Birthplace:

16. Informant: Walter Hyde

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 24 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Mar 24 19 45 (Date rec'd by registrar) Winter K. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 19 45 at 1P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-23-45 19 to 3-21-45 19 and that I last saw him alive on 3-21-45 19

	DURATION
Immediate cause of death: Carcinoma sigmoid	6 mo.
Due to: Intestinal obstruction	2 wks.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: C C Zimmerman M.D. M. D. or other

Address: Cumberland, Md. Date signed: 3-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. JACOBSON
DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02438

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: BARTON
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MR. WILLIAM H. HYDE

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: DAISY HYDE
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): JULY 30, 1902

8. AGE: Years	Months	Days	If less than one day
42	7	2	hrs. min.

9. Birthplace: BARTON, MD.
(Town, county, and state)
10. Usual occupation: MERCHANT
11. Industry or business: Own Grocery Store

FATHER
12. Name: WILLIAM HYDE
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: SARAH KIRKPATRICK
15. Birthplace: MARYLAND

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 4, 1945 (Month) (day) (year)
Cemetery or crematory: Laurel Hill Cem
Location: Morcow, Md.
18. Funeral director: E. Ellsworth S. Boal.
Address: Westernport, Md.

19. March 7, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 2, 1945 19..., at 3:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAR. 1, 1945, to MAR. 2, 1945 and that I last saw him alive on MAR. 1, 1945

	DURATION
Immediate cause of death: Catarrhal Jaundice	3 days
Due to: Infection and Toxemia	??
Due to:	
Other conditions: Mitral Insufficiency	??
Myocardial Weakness & failure	??

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed 3/2/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

02439

2411 N. Charles St., Baltimore (835)

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs 10 mos 24 days
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midland
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Annie Stevens Jeffries

3.(b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John H. Jeffries
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): April 19, 1878
8. AGE: Years: 66 Months: 10 Days: 24 If less than one day: hrs. min.
9. Birthplace: Midland, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own home
FATHER 12. Name: Samuel Stevens
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: England
16. Informant: Mrs. Elmer Jeffries
Address: Midland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 15, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: Eichhorn
Address: Lonaconing, Md.
19. March 15 1945 (Date rec'd by registrar) Dr. S. Odell Tyson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13, 1945, at 6:59 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 1945 to March 13 1945 and that I last saw h[er] alive on March 13 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: J. Henry H. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: March 15 '45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

02440

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
29 Bealls Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 29 Bealls Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie C. Keller

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife John Keller 6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 11, 1871

8. AGE:

Years	Months	Days	If less than one day
73	11	14	hrs. min.

9. Birthplace Frostburg Allegany Cty. Md (Town, county, and state)
10. Usual occupation housewife
11. Industry or business home
FATHER 12. Name Zachariah Krapf
13. Birthplace Germany
MOTHER 14. Maiden name Sarah Geis
15. Birthplace Maryland
16. Informant John D. Keller
Address Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 28 1945 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg Md.
18. Funeral director J. J. Obrist
Address Frostburg Md
19. 3-27 1945 Mrs. Nancy L. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1945, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1941 to March 26 1945 and that I last saw h.. alive on March 25 1945.

	DURATION
Immediate cause of death Hypertensive Cardio-vascular Disease	6 Yrs.
Due to	
Due to Arterio-Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations X Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide X Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. C. Diehl, M.D. M. D. or other
Address Frostburg, Md. Date signed 3/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

02441

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred: 311 Frederick St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 Frederick

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Juanita L. Kelley

3.(b) Social Security Number: 217-18-5590

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: John Kelley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 17 1912

8. AGE: Years: 32 Months: 9 Days: 27 If less than one day: ..... hrs. ..... min.

9. Birthplace: Johnstown, Pennsylvania (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Former Celanese Corp. Employee

FATHER — 12. Name: Walter Lee

FATHER — 13. Birthplace: No Carolina

MOTHER — 14. Maiden name: Kathie Gordon

MOTHER — 15. Birthplace: Va.

16. Informant: Helen Edwards

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 12 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Mar. 12, 1945 (Date rec'd by registrar) Walter R. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8, 1945, at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1945 to March 8 1945

and that I last saw h[illegible] alive on March 6 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8
Due to	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M A Bowers M. D.

Address: 133 Va Ave Date signed: 3/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

02442

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 767 Md. Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Franklin Sylvester Kennell

3.(b) Social Security Number 705-09-5520

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret Ellen Hutzell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 15, 1879

8. AGE: Years	Months	Days	If less than one day
66	0	10	..... hrs. ..... min.

9. Birthplace: Meyersdale Somerset Co. Pa. (Town, county, and state)

10. Usual occupation: Passenger Conductor

11. Industry or business: B & O. Railroad

FATHER — 12. Name: John Kennell

FATHER — 13. Birthplace: Kennells Mill, Pa.

MOTHER — 14. Maiden name: Eliz Boone

MOTHER — 15. Birthplace: Kennells Mill Pa.

16. Informant: Mrs. Frances Travis

Address: 767 Md. Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 28 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Mar 27, 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25th 1945, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 20, 1945, to Mar. 25, 1945

and that I last saw her alive on Mar. 25, 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 Hrs.
Due to: Chronic myocarditis	6 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Frank R. Travis M. D. or other

Address: Cumberland Date signed 3/26/45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

02443

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 yrs

Hospital, Institution, or street address where death occurred:

12 Centennial Street

How long in hospital or institution? ~

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Centennial St

(If rural, give LOCATION)

2.(a) If veteran, name war: ~

3.(a) FULL NAME

Johanna Knieriem

3.(b) Social Security Number

~

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George Knieriem

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Jan 30 1865

8. AGE:

Years	Months	Days	If less than one day
80	1	2	...hrs. ...min.

9. Birthplace: Hoffman, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER

12. Name: Wm Schell

13. Birthplace: Germany

MOTHER

14. Maiden name: Frederica Schmidt

15. Birthplace: Germany

16. Informant: Mrs Robert Gleuwellyn

Address: 10 Centinial St Frostburg Md

17. Burial, cremation, or removal. Which? Burial Date thereof (month) Mar 7 (day) (year) 1945

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md

19. Funeral director: Jacob Faber

Address: Frostburg Md

19. (Date rec'd by registrar) 3-5 19 45 Mrs Nancy N Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 19 45, at 10:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-9 19 40 to 3-4 19 45

and that I last saw h. alive on 3-4 19 45

Immediate cause of death	DURATION
Chronic myocarditis	10 yrs.
Due to Arterio-sclerosis. Senility.	10 yrs.
Due to Diabetes Mellitus	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ...Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed 3/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

02444

CERTIFICATE OF DEATH

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, institution, or street address where death occurred:
11 High St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 11 High St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: SUSAN E. KNIERIEM

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Conrad Knieriem
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 11, 1867

8. AGE: Years	Months	Days	If less than one day
78	1	19	..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany, Maryland (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Anthony Gerlach.
13. Birthplace: Frostburg, Md.

MOTHER
14. Maiden name: Henrietta Conrad.
15. Birthplace: Frostburg, Md.

16. Informant: Rachel Knieriem.
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 5, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery.
Location: Frostburg, Md.

18. Funeral director: J. J. Durst.
Address: Frostburg, Md.

19. 3-3 (Date rec'd by registrar) 19 45 Mrs. Nancy V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 2 19 45, at 1 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 19 ..... to Mar 2 19 45 and that I last saw h... alive on Mar 1 19 45

Immediate cause of death: (a) Chronic Myocarditis — DURATION: 2 years
Due to: Hypertension — General 4 years
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. D. McLane M.D. M. D. or other
Address: Frostburg Md. Date signed 3-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27-C

02445

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Cresaptown, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James Edwin Kubes 2nd.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 23, 1941

8. AGE:

Years	Months	Days	If less than one day
4	1	7	..... hrs. ..... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Edwin C. Kubes

13. Birthplace: W. Va.

MOTHER

14. Maiden name: Hope McBride

15. Birthplace: W. Va.

16. Informant: Edwin C. Kubes

Address: Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 2, 1945 (month) (day) (year)

Cemetery or crematory: HillCrest Burial Park

Location: Near Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Apr 2 1945 (Date rec'd by registrar) M. K. Hammett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 31, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1945, to March 31 1945

and that I last saw him alive on March 30 1945

Immediate cause of death	DURATION
Dysentery	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: T. Barclay Hunter M.D.
M. D. or other

Address Date signed

(M)

02446

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

Reg. Dist. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Jane Lashley
3.(b) Social Security Number: none

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 10 — 1874
8. AGE: Years 70 | Months 9 | Days 11 | If less than one day ..... hrs. ..... min.
9. Birthplace: Bedford City, Pa.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Albert Lashley
13. Birthplace: Pennsylvania
MOTHER 14. Maiden name: Dorcas Robinette
15. Birthplace: Pennsylvania
16. Informant: Benjamin Lashley
Address: Mt. Savage Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 24-1945 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Mt. Savage Md.
18. Funeral director: J. J. Dent
Address: Frostburg Md.
19. March 21 19 45 (Date rec'd by registrar) Veronica McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 19 45 at 7a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 19 45 to March 21 19 45
and that I last saw h... alive on March 20 19 45

	DURATION
Immediate cause of death: Coronary Obstruction of Heart	2 days
Due to: Bronchial asthma	4 mos
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Allan G. Plummer M. D. or other
Address: Cumberland Md. Date signed: March 21 45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02447

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred: Allegany County Infirmary

How long in hospital or institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Zihlman

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. D. No 2 Frostburg, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Joseph Lewis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 30 1875

8. AGE: Years 69 | Months 10 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace Zihlman, Allegany, Md. (Town, county, and state)

10. Usual occupation Retired Miner

11. Industry or business Coal

FATHER 12. Name John S. Lewis

FATHER 13. Birthplace Wales

MOTHER 14. Maiden name Myra Langford

MOTHER 15. Birthplace Wales

16. Informant Mrs. Myra Anderson

Address Zihlman, Route 2 Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-25-1945 (month) (day) (year)

Cemetery or crematory Jersey Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Kafer

Address Frostburg, Md.

19. Nov. 24, 1945 (Date rec'd by registrar) Minter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1945, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 3, 1939, to March 23, 1945

and that I last saw him alive on March 21, 1945

Immediate cause of death: Coronary Thrombosis — DURATION: Short

Due to: Coronary Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None — Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other

Address Cumberland Date signed 3-24-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

02448

Reg. Dist. No. 14

1. PLACE OF DEATH:
County: Allegany
City or town: Ellerslie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna. County: Bedford
City or town: Hyndman Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Sarah Ellen Corley Leydig

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: Wenfield Scott Leydig
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 2, 1868

8. AGE: Years	Months	Days	If less than one day
76			hrs. min.

9. Birthplace: Manns Choice RD. Bedford Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: James Corley
13. Birthplace: Pa.

MOTHER
14. Maiden name: Mary Sherman
15. Birthplace: Pa.

16. Informant: Mrs. C. D. Mull
Address: Ellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 18, 1945 (month) (day) (year)
Cemetery or crematory: Lybargers Cemetery
Location: Hyndman Rural, Bedford Co. Pa.

18. Funeral director: Harvey T. Feigley
Address: Hyndman Pa.

19. March 17 1945 (Date rec'd by registrar) J. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13th 1945 at 10-30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3rd 1945 to March 13th 1945
and that I last saw her alive on March 13th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 months
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. Brant M. D. or other
Address: Schellsburg Date signed: 3-17-45

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02449

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Ridgeley

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs Alice Va. Sloyd

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Wm. Sloyd.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 10, 1881

8. AGE: Years: 63 | Months: 9 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Shenandoah Va.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home

FATHER

12. Name: George Parrish

13. Birthplace: Va.

MOTHER

14. Maiden name: Frances Davis

15. Birthplace: Va.

16. Informant: Mrs Sarah Barnhill

Address: 616 W. Hamburg St - Balto Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 26 1945 (month) (day) (year)

Cemetery or crematory: Abe Cemetery

Location: Near Ridgeley W. Va.

18. Funeral director: John J. Hafer

Address: Cumberland Md

19. Mar 26 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23, 1945 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1945 to March 24 1945 and that I last saw h.. alive on March 24 1945

Immediate cause of death	DURATION
Encephalitis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. B. Heasters M. D. M. D. or other

Address: 49 Greene St Date signed: 3-26-45

(M) MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02450

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U. Maryland R.R. Tracks

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va County Mineral

City or town Wiley Ford

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Charles Albert McAbee

3.(b) Social Security Number 214-05-9262

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Virginia M. Beatty

6.(c) If alive, give age 4 years

7. Birth date of deceased (mo., day, yr.) Aug 19, 1884

8. AGE: Years	Months	Days	If less than one day
60	6	25	...hrs. ...min.

9. Birthplace Brunswick Md.
(Town, county, and state)

10. Usual occupation Box Builder

11. Industry or business Cumberland Box Co.

FATHER 12. Name Zack McAbee

13. Birthplace Sandy Hook, Md.

MOTHER 14. Maiden name Edith M. Bond

15. Birthplace Weaverton Md.

16. Informant Mrs John Hill

Address 29 Oak St. Cumb. Md.

17. Burial Date thereof Mar 17 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oaklawn Cemetery

Location Riverside W. Va

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Mar 16 1945 Wilbur R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1945, at 6:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...1945, to ...1945

and that I last saw h... alive on ...1945

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Pierce H. Brown M.D.
M. D. or other

Address Cumberland, Maryland Date signed 3-15-45

Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

02451

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred: Douglas Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Laura Viola McCormack

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas M. Cormack
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Dec. 6, 1878

8. AGE:

Years	Months	Days	If less than one day
66	3	13	hrs. min.

9. Birthplace: Barton, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Own home
12. FATHER — Name: Dennis Preston
13. FATHER — Birthplace: Unknown
14. MOTHER — Maiden name: Sarah Poland
15. MOTHER — Birthplace: Unknown
16. Informant: Mrs. Fred Stoudt
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 22, 1945 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Lonaconing, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.

19. March 20, 1945 (Date rec'd by registrar) D. E. Offutt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19, 1945, at 4:12 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1941, to March 19, 1945 and that I last saw h[illegible] alive on March 19, 1945

Immediate cause of death	DURATION
Cardiac Enlargement	1 yr.
general weakness	6 mos.
Due to: Diabetes Mell.	3½ yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. E. Offutt, M. D. or other
Address: Lonaconing Date signed: 3/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-a)

CERTIFICATE OF DEATH

02452

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred: 378 N. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 378 N. Mechanic St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Cecelia Eva McKenzie

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jos. A. McKenzie

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25 1887

8. AGE: Years: 57 | Months: 11 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Wyndmoor Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Jos. Whitacre

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Amanda Butts

MOTHER — 15. Birthplace: Pa.

16. Informant: Joseph A. McKenzie

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 27 45 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland

18. Funeral director: Long & Stine Inc

Address: Cumberland

19. Mar 21 19 45 (Date rec'd by registrar) Hunter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 19 45, at 3 30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from did not attend 19 to 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death: Coronary Thrombosis Heart Disease	Sudden
Due to: Chronic Nephritis	7 yrs
Due to: Arteriosclerosis	20 yrs
Other conditions: Died Suddenly. Sitting in Chair	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos. A. Kraus M. D. or other

Address: Cumberland Md Date signed: 3/20/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-21)

CERTIFICATE OF DEATH

02453

Reg. Dist. No. 4

1. PLACE OF DEATH: ALLEGANY

County

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: MEMORIAL Hospital

How long in hospital or institution? 1½ DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 201 THOMAS ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME MRS
MRS WILHELMINA McMULLEN

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: FRANK McMULLEN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): AUGUST 30, 1891

8. AGE: Years	Months	Days	If less than one day
53	6	16	..... hrs. ..... min.

9. Birthplace: MD.
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER — 12. Name: WALTER ~~SCHOOLICK~~ Scollick

FATHER — 13. Birthplace: MD.

MOTHER — 14. Maiden name: ISABELL JEFFRIES

MOTHER — 15. Birthplace: SCOTLAND

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 18, 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cem

Location: Lonaconing Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing Md.

19. Mar. 17 '45 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16, 1945 at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 12, 1945 to Mar. 16, 1945 and that I last saw her alive on Jan. 15, 1945

Immediate cause of death	DURATION
Uremic Alcoholism	6 wks
Cancer of Liver	?
Due to: Uraemia	10 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clark Lucas M. D., or other

Address Cumberland Date signed 3/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

02454

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years

Hospital, institution, or street address where death occurred: Jackson Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Jackson St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Robert R Meerbach

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jessie Matthews

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Oct 1, 1878

8. AGE:

Years	Months	Days	If less than one day
66	5	8	....hrs. ....min.

8. Birthplace: Barton, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Miner Fireman

11. Industry or business: Big Vein Coal Co. Lonaconing

FATHER 12. Name: Gottlieb Meerbach

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Mary Russell

MOTHER 15. Birthplace: Unknown

16. Informant: Mrs. Robert Lowe

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: W. Eichhorn

Address: Lonaconing, Md.

19. March 4 1945 (Date rec'd by registrar) D. E. Bowman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1st 1945, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944, to March 1st 1945 and that I last saw h... alive on March 1st 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Cerebral Hemorrhage Dec. 1944	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: N.O. Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury Injured at work?

23. SIGNATURE: Henry M. Hodgson M. D. or other

Address: Lonaconing, Md. Date signed: March 5 '45

M

1

4

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

02455

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 1 mo. 3 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 536 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Margaret Meisel

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb 12 1876

8. AGE: Years 68 | Months 1 | Days 4 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER 12. Name: Peter Meisel

13. Birthplace: Germany

MOTHER 14. Maiden name: Louise Reitt

15. Birthplace: Germany

16. Informant: Mrs Augusta Smith (E.S.)

Address: 1375 Queen St Martinsburg W Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 20 45 (month) (day) (year)

Cemetery or crematory: Trinity Lutheran Co.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Mar 20, 19 45 (Date rec'd by registrar) Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 19 45 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 13 19 45 to Mch 16 19 45

and that I last saw h alive on Mch 16 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions Diabetes, Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L B Matthews M.D. M. D. or other

Address: 49 Greene St Date signed: 3-17-45

DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02456

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 31 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: PENNSYLVANIA County: CAMBRIA
City or town: JOHNSTOWN
(If outside city or town limits, write RURAL and give nearest town)
Street No. 80 VALLEY PIKE
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MOLLIE V. MILLER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: FOSTER MILLER

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JAN. 17, 1878

8. AGE: Years	Months	Days	If less than one day
67	1	28	..... hrs. ..... min.

9. Birthplace: PENNSYLVANIA (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER — 12. Name: JAYSON HARBAUGH; 13. Birthplace: PENNSYLVANIA

MOTHER — 14. Maiden name: AMANDA CUPPETT; 15. Birthplace: PENNSYLVANIA

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal, which?) Date thereof Mar 19 1945 (month) (day) (year)
Cemetery or crematory: Pleasantville
Location: Glen Burk, Pa.

18. Funeral director: Harvey H. Zeigler
Address: Hyndman Pa.

19. Mar. 16 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 15 19 45, at 2:20 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19 44, to March 19 44
and that I last saw her alive on March 15 19 45

	DURATION
Immediate cause of death: Carcinoma	
Due to: Sigmoid Colon	2 Yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Tapper M.D. M. D. or other
Address: Hyndman Pa. Date signed 3/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02457

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred: 203 Maple St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 203 Maple St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Cordelia Minnick

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Robert Minnick

6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Oct. 2nd 1874

8. AGE: Years 70 Months 5 Days 7 If less than one day ... hrs. ... min.

9. Birthplace Garrett Co. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Jacob McKenzie

13. Birthplace Garrett County, Md

MOTHER 14. Maiden name Fanny Christner

15. Birthplace Somerset, Pa.

16. Informant Mrs Marian Murphy

Address 203 Maple St. Frostburg, Md

17. Burial Date thereof 3-12-1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory McKenzie Cem. Garrett Co

Location State Route Frostburg, Md

18. Funeral director Jacob Shafer

Address Frostburg, Md.

19 3-10 (Date rec'd by registrar) 19 45 Mrs. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 19 45, at 7:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 19 44, to March 9 19 45

and that I last saw her alive on March 9 19 45.

Immediate cause of death Hypertensive cardio-vascular disease DURATION 5 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations X

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Diehl M.D. M. D. or other

Address Frostburg, Md. Date signed 3/9/45

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

02458

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital Cumberland Md

How long in hospital or institution? 5 hrs 40 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Hampshire

City or town: Springfield
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Moreland, Sandra Ellen

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 20th, 1942

8. AGE: Years: 2 | Months: 10 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Md
(Town, county, and state)

10. Usual occupation: Child

11. Industry or business:

FATHER 12. Name: Kenneth Moreland

FATHER 13. Birthplace: W. Va.

MOTHER 14. Maiden name: Maybelle Lewis

MOTHER 15. Birthplace: W. Va.

16. Informant: G. Kenneth Moreland

Address: Springfield, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 11, 1945 (month) (day) (year)

Cemetery or crematory: Wesley Chapel Cem

Location: Points, W. Va.

18. Funeral director: Shreve's

Address: Romney, W. Va.

19. Mar. 11 (Date rec'd by registrar) 19 45 Walter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/8 1945, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/7 1945 to 3/8 1945

and that I last saw her alive on 3/7/45 1945

	DURATION
Immediate cause of death: extensive burns 1° 11° and III degree	2 days 6 hrs
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~: yes Date of 3/7/44

Where did injury occur? Hampshire County Springfield (City or town) W Va (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury: playing with matches Injured at work? no

23. SIGNATURE: L. Brown MD
M. D. or other

Address: Long Mod Date signed: 3-12-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

02459

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: B & O. Railroad Station - Baggage Room

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 519 City View Terrace

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Chester Allen Morgan

3.(b) Social Security Number

220-10-2009

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lina Oster

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 29, 1891

8. AGE: Years	Months	Days	If less than one day
53	10	17	..... hrs. ..... min.

6. Birthplace: Green Ridge Allegany Co, Md.

(Town, county, and state)

10. Usual occupation: Baggage Agent

11. Industry or business: B & O Railroad

FATHER 12. Name: Samuel C. Morgan

FATHER 13. Birthplace: Green Ridge, Md

MOTHER 14. Maiden name: Mary Pollman

MOTHER 15. Birthplace: Cass Pan W. Va

16. Informant: Thos Morgan

Address: Route 3 - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 20 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Methodist Cem.

Location: Beaus Cove Road

16. Funeral director: John J Haley

Address: Cumberland Md

19. March 20 1945 (Date rec'd by registrar) Hunter R Dent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16th, 1945, at 5:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: no Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Lewis H. Brown M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 3-16-45

County Medical Examiner - Allegany Co

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

02460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 14 Bowery St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME James David Neal

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/20/45

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: Frostburg Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: James Alexander Neal
13. Birthplace: Frostburg Md

MOTHER
14. Maiden name: Mary Margaret Hopkins
15. Birthplace: Frostburg Md

16. Informant: James A. Neal
Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 23-45 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md

18. Funeral director: J. J. Dearst
Address: Frostburg Md.

19. 3-23 (Date rec'd by registrar) Miss Nancy V. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1945, at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/20 1945, to 3/22 1945 and that I last saw h. alive on 3/21 1945

Immediate cause of death	DURATION
Cerebral injury	2 days
Due to: Apnoea	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Hilda Jane Walters M.D.
M. D. or other
Address: Frostburg Date signed: 3/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

02461

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 16 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEG.
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 ALTAMONT TERRACE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MR. PERRY A. NICKLIN

3.(b) Social Security Number: 220-10-0580

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MARGUERITE JANSSEN
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): OCT. 19 1880

8. AGE: Years	Months	Days	If less than one day
64	5	9	hrs. min.

9. Birthplace: Barrow Ind. (Town, county, and state)
10. Usual occupation: Mfg. & Salesman
11. Industry or business: Paving material

FATHER
12. Name: JAMES W. NICKLIN
13. Birthplace: VA.

MOTHER
14. Maiden name: LYDIA PERRY
15. Birthplace: ENGLAND

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 30 45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.
16. Funeral director: Louis Stine Sons
Address: Cumberland, Md.

19. 3/30/45 (Date rec'd by registrar) Walter R. Frantz, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 28, 1945 at 4 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-6- 1945 to 3-28- 1945 and that I last saw him alive on 3-25- 1945

	DURATION
Immediate cause of death: Acute Glomerulo Nephritis	3 mos
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.: None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. E. Williams M. D. or other
Address: Cumberland Md. Date signed 3-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02462

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 41 yrs.
Hospital, institution, or street address where death occurred: 18 East Oldtown Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 18 East Oldtown Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Wheeler Costello Poling
3. (b) Social Security Number None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Divorced
6.(b) Name of husband or wife: Ora E Ferguson
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct 20 1876

8. AGE:

Years	Months	Days	If less than one day
68	5	9	... hrs. ... min.

9. Birthplace: Greene Co Pa.
(Town, county, and state)
10. Usual occupation: Pipe fitter
11. Industry or business: Celanese (Retired)

FATHER
12. Name: Andrew J. Poling
13. Birthplace: Pa.

MOTHER
14. Maiden name: Maria Robinson
15. Birthplace: Pa.

16. Informant: Mrs Chas T. Hare
Address: 18 East Oldtown Rd

17. Burial — Date thereof: April 1 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory: Hillcrest Burial Park
Location: Cumberland Md

18. Funeral director: Gary Stein Inc
Address: Cumberland, Md

19. April 1, 1945 — Winter R. Frantz, M.D.
(Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1945, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18 1945, to March 29 1945 and that I last saw him alive on March 29 1945

	DURATION
Immediate cause of death: Coronary occlusion	10 min
Due to: Coronary disease	1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: M E B Owens M.D.
M. D. or other
Address: 133 Va ave
Date signed: 3/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

02463

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25. Years

Hospital, institution, or street address where death occurred:

Rt # 1. LaVale

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt # 1. LaVale

(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 1.

3. (a) FULL NAME

Robert Lee Radcliffe

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie Radcliffe

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): April 9 1891

8. AGE: Years	Months	Days	If less than one day
53	11	11	...hrs. ...min.

9. Birthplace: Vale Summit, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business: Meat Market

FATHER

12. Name: Joseph Radcliffe

13. Birthplace: Vale Summit, Md.

MOTHER

14. Maiden name: Eva Long

15. Birthplace: Pala Alto, Pa

16. Informant: Joseph F. Radcliffe

Address: LaVale, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/22/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Mar. 22 19 45 (Date rec'd by registrar) Victor R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20, 1945 19..., at 5-AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 44 to March 19 19 45 and that I last saw h... m/ alive on March 19 19 45

Immediate cause of death: congestive heart failure — DURATION: 1 yr.

Due to: myocardiopathia

Due to: —

Other conditions: Bright's disease — about 10 yr.

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Elizabeth G. Bragg, M.D. M. D. or other

Address: Long, Md. Date signed 3/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02464

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Miller Mine near Midland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Miller Mine near Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Felix Robertson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 31, 1889

8. AGE: Years	Months	Days	If less than one day
55	4	1	hrs. min.

8. Birthplace: Miller Mine Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business: Big Vein Coal Co of Lonaconing

FATHER 12. Name: Joseph G Robertson

FATHER 13. Birthplace: Eckhart, Md.

MOTHER 14. Maiden name: Drucilla Foote

MOTHER 15. Birthplace: Lonaconing, Md.

16. Informant: Mrs Richard Elliott

Address: Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 6, 1945 (month) (day) (year)

Cemetery or crematory: Old Coney Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eichbaum

Address: Lonaconing, Md.

19. March 6 1945 (Date rec'd by registrar)

D. E. Owen Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2nd., 1945, at about 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..., 19..., to ..., 19...; and that I last saw h... alive on ..., 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis H. Bourn M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 3-3-45

Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75

02465

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 1 HOUR 35 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: OLDTOWN, MD (If outside city or town limits, write RURAL and give nearest town)
Street No.: ROUTE #1 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MR. ~~FRED ROBINETTE~~ Frederick L. Robinette

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MRS. BLANCHE ROBINETTE
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): APRIL 26, 1878

8. AGE: Years	Months	Days	If less than one day
66	10	21	hrs. min.

9. Birthplace: MARYLAND - Twiggtown, Alleg Co (Town, county, and state)
10. Usual occupation: FARMER
11. Industry or business: Own Farm
12. FATHER — Name: JESS M. ROBINETTE
13. FATHER — Birthplace: MARYLAND - Twiggtown
14. MOTHER — Maiden name: RUHAMEY HAMILTON
15. MOTHER — Birthplace: MARYLAND - Twiggtown
16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 19 1945 (month) (day) (year)
Cemetery or crematory: Stallings Cemetery
Location: Near Oldtown Md
18. Funeral director: John J. Hafer
Address: Cumberland Md.
19. Mar 19 1945 (Date rec'd by registrar) Winter F. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAR. 17, 45 7:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 '43 to March 17 1945
and that I last saw h alive on March 17 1945

Immediate cause of death	DURATION
Acute Dilitation of Heart.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A C Dodrill M. D. or other
Address: Cumberland Date signed 3/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02466

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: On way to Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 804 Kentucky Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Shirley Joanne Rowley

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 30, 1934

8. AGE: Years	Months	Days	If less than one day
10	3	12	hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Md (Town, county, and state)

10. Usual occupation: School child

11. Industry or business

FATHER — 12. Name: Edwood Rowley

13. Birthplace: Cumberland Md

MOTHER — 14. Maiden name: Elizabeth Rutherford

15. Birthplace: Unknown

16. Informant: Mrs. Gertrude Collins

Address: 804 Kentucky Ave - Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 15, 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Mar. 14, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12, 1945, at 7:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 1945, to March 12, 1945

and that I last saw her alive on March 12, 1945

Immediate cause of death	DURATION
Rheumatic Fever	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Winter R. Frantz M.D. M. D. or other

Address: 15 S. Liberty St. Date signed: 3/13/45

Jacobson

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02467

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 206 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Wm. Ambrose Ryland

3. (b) Social Security Number 213-16-9170

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 15. 1888

8. AGE: Years	Months	Days	If less than one day
56	3	18	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Clerk.

11. Industry or business K.S. Tire Co.

FATHER 12. Name James L. Ryland

13. Birthplace Cumberland Md.

MOTHER 14. Maiden name Bridget Dolan

15. Birthplace Ireland.

16. Informant Joseph J. Ryland.

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 6 '45 (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumberland.

16. Funeral director Louis Stein Inc.

Address Cumberland.

19. Mar. 5 19 45 Winter R. Frantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3 19 45 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/18/45 19 to 3/3/45 19

and that I last saw him alive on 3/3/45 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions Tuberculous Bronchitis	

(Include pregnancy within 3 months of death)

Major findings of operation Tuberculous Abdomen

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John N. Rowland M.D.
M. D. or other

Address Cumberland Md. Date signed 3/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

02468

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 yrs.

Hospital, institution, or street address where death occurred: 533 Columbia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 533 Columbia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Schade.

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Nicholas Schade

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feb 17 1867

8. AGE:

Years	Months	Days	If less than one day
78	0	16	hrs. min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home.

FATHER 12. Name: Conrad Ruhl

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Mary Sleminer

MOTHER 15. Birthplace: Germany.

16. Informant: J. Henry Schade

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 6 45 (month) (day) (year)

Cemetery or crematory: St Lukes Cem.

Location: Cumberland

18. Funeral director: Downs Stein Inc

Address: Cumberland

19. March 6, 1945 (Date rec'd by registrar) Victor R. Trauth M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 1945, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Mar 3 1945

and that I last saw her alive on Mar 1 1945

Immediate cause of death	DURATION
Generalized	
Due to: Uterine Cancer	7
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date Signed 3-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

02469

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Dr. Grove

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 1/2 yrs

Hospital, Institution, or street address where death occurred:

728 Gephart Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 728 Gephart Drive (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Julian Schanwecker

3.(b) Social Security Number 214-05-7864

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Bertha Apple

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 2 1883

8. AGE: Years 61 | Months 8 | Days 4 | If less than one day ..... hrs. ..... min.

8. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Pres. & Genl Mgr.

11. Industry or business Glass Co

FATHER 12. Name Robert Schanwecker

13. Birthplace Germany

MOTHER 14. Maiden name Sophia Greissman

15. Birthplace Germany

16. Informant Mrs R J. Schanwecker

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 9 45 (month) (day) (year)

Cemetery or crematory Fellowship Cem.

Location Cumberland

18. Funeral director Louis Stein Sons

Address Cumberland

19. Mar 9 1945 (Date rec'd by registrar) Winter R. Hauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 9 45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 6, 1945, to Mar. 6, 1945, and that I last saw h.. alive on March 6 1945

Immediate cause of death	DURATION
Coronary Sclerosis	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE D. G. Grove M.D. M. D. or other

Address Medical Bldg Date signed 3-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02470

1454

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 Years 2 Mo 9 Days

Hospital, institution, or street address where death occurred:

415. Greene St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 415. Greene St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sylvester Schilling

3. (b) Social Security Number: 220-10-9278

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Ida Schilling

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): December 31, 1873

8. AGE: Years	Months	Days	If less than one day
71	2	9	...hrs. ...min.

9. Birthplace: Cumberland, Allegany Co, Maryland (Town, county, and state)

10. Usual occupation: United States Post Office Clerk

11. Industry or business: Post Office

FATHER

12. Name: Edward Schilling

13. Birthplace: Hayesville, Indiana

MOTHER

14. Maiden name: Barbara Dollhopf

15. Birthplace: Germany

16. Informant: Mrs. Sylvester Schilling

Address: 415. Greene St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/13/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: Willian H. Kight

Address: Cumberland, Md.

19. Mar. 12, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1945, at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-10 1945, to 3-10 1945 and that I last saw h.. alive on March 10 1945

Immediate cause of death	DURATION
Chronic Myocarditis	1 yrs.
Due to: Arteriosclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: I. W. Eleanor M.D. M. D. or other

Address: 126 Greene St Cumberland Md. Date signed 3/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAR 16 1945
BUREAU V.S.

Dr. Eliason

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1156)

CERTIFICATE OF DEATH

02471

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 yrs

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 212 Schley Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr. Frank L. Schriver

3.(b) Social Security Number 214-05-6608

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret Eyler

6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) July 24 1903

8. AGE: Years	Months	Days	If less than one day
41	8	4	...hrs. ...min.

9. Birthplace ~~Maryland~~, Cumberland Rd (Town, county, and state)

10. Usual occupation

11. Industry or business Allegany Ballistics Lab.

FATHER 12. Name Joseph S. Schriver

13. Birthplace Maryland

MOTHER 14. Maiden name Martha Daugherty

15. Birthplace Maryland

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof Mar 31 45 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem

Location Cumberland

18. Funeral director Louis Stein Sons

Address Cumberland

19. 3/30 19 45 Walter R. Frantz M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 19 45 at 3:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 45 19 to March 28 19 45 and that I last saw h.. alive on March 27 19 45

	DURATION
Immediate cause of death Acute Nephritis	9 days
Due to Streptococcus infection of throat	4 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Eliason M. D. or other

Address 1 Kenmore Cumberland Md Date signed 3-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

02472

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 407 Fairmont St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Fred Seitz

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Anna M. Zinn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 14 1868

8. AGE: Years 77 | Months — | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace New York City N.Y.
(Town, county, and state)

10. Usual occupation Ry Fireman

11. Industry or business Retired

FATHER
12. Name Fred Seitz
13. Birthplace Germany

MOTHER
14. Maiden name Josephine Bronsenheart
15. Birthplace Germany

16. Informant Mrs Bertha Beitz
Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 15 45 (month) (day) (year)
Cemetery or crematory St Lukes Cem.
Location Cumberland

18. Funeral director Louis Stein Sons
Address Cumberland

19. March 15, 19 45 (Date rec'd by registrar) Winter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1945 at 945 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 1945 to March 12 1945 and that I last saw him alive on March 12 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Uraemia	several days
Due to	
Hypertension Heart	2 or 3 months
Due to	
Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE J. Allan Glenn M.D.
M. D. or other
Address Cumberland Md Date signed March 13 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

02473

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 81 yrs.

Hospital, Institution, or street address where death occurred:

523 Greene St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 523 Greene St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Michael J. Sell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Margaret J Werner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 18 1863

8. AGE: Years	Months	Days	If less than one day
81	5	13	..... hrs. ..... min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation Contractor (Retired)

11. Industry or business Stone & Cement

FATHER 12. Name Simon Sell

13. Birthplace Germany

MOTHER 14. Maiden name Mary Werner

15. Birthplace Germany

16. Informant Norman Sell

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 3 45 (month) (day) (year)

Cemetery or crematory St. Peter & Paul's Cem

Location Cumberland Md.

18. Funeral director Louis Stein Son

Address Cumberland

19. April 1, 19 45 Winter L. Beatty M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 45 at 8 [illegible] M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 7 - 45 19.. to Mar 31 19 45

and that I last saw h.. alive on Mar 29 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs.
Due to	
Due to	
Other conditions Arteriosclerosis	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE C. A. Trevaskis, M.D.

M. D. or other

Address Cumberland, Md Date signed Apr 2 - 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

CERTIFICATE OF DEATH

02474

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryladd
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 39 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 304 Columbia Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mr. David W. Shearer

3.(b) Social Security Number: 703-07-9021

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna Pearl Cutter
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): March 2 1892

8. AGE: Years	Months	Days	If less than one day
53	-	7	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Carman
11. Industry or business: B & O Railroad
FATHER 12. Name: William Shearer
FATHER 13. Birthplace: Scotland
MOTHER 14. Maiden name: Mary Goodrich
MOTHER 15. Birthplace: Maryland
16. Informant: Memorial Hospital
Address: Cumberland, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 12 45 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland
18. Funeral director: Louis Stein Sons
Address: Cumberland.
19. Mar 15, 1945 (Date rec'd by registrar) Winters R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9 1945 at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1944 to March 9 1945 and that I last saw him alive on March 9 1945

Immediate cause of death	DURATION
Hemoperitoneum	??
Cirrhosis of Liver	??
Due to	
Due to	
Other conditions: Jaundice	2 wks.
Anemia	1 wk.
(Include pregnancy within 3 months of death) Acute Duodenal Ulcer	1 mo.

Major findings of operation:
Date of op.:
Autopsy results: To be reported later.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Stanley Jacobson M. D. or other
Address: 15 S. Liberty St. Date signed: 3/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Jacobson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

02475

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 304 South Centre Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Peter Shimbo

3.(b) Social Security Number: 220-10-7990

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 8, 1894

8. AGE: Years	Months	Days	If less than one day
50	3	11	..... hrs. ..... min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: Owner

11. Industry or business: City Auto Laundry

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 22, 1945 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. March 21, 1945 (Date rec'd by registrar) Hunter R. Harris M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19, 1945, at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28, 1945, to March 19, 1945 and that I last saw h[illegible] alive on March 19, 1945

	DURATION
Immediate cause of death: Pulmonary Edema (Acute)	1 day
Due to: Myocardial Disease - Marked Arteriosclerosis	Yrs. (?)
Due to: Mitral Insufficiency	?
Other conditions: Diabetes Mellitus	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed 3/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

02476

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany County Infirmary

How long in hospital or institution? 10 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mc General Delivery
(If outside city or town limits, write RURAL and give nearest town)

Street No. Frostburg, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter O. Shriver

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Katherine Eisel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 13 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
77	11	7		

9. Birthplace Borden Mines Allegany, Md.
(Town, county, and state)

10. Usual occupation Retired Coal Miner

11. Industry or business

FATHER 12. Name Henry Shriver

13. Birthplace Frostburg, Md.

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Chas. C. Shriver

Address General Delivery Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-12-1945 (month) (day) (year)

Cemetery or crematory Porter Cemetery

Location Eckhart Mines, Md.

18. Funeral director Jacob Dafler

Address Frostburg, Md.

19. Mar. 12, 1945 (Date rec'd by registrar) Pinter L. Fantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-10-1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 29 1944 to 3-10-1945 and that I last saw him alive on 3-7-1945

Immediate cause of death	DURATION
Uremia	
Myocardial Degeneration	
Due to: Diabetes Mellitus	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 3-13-45

Williams

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

02477

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, institution, or street address where death occurred: 52 W. Lee St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: 52 W. Lee St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Catherine M. Simons

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William R. Simons

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1855

8. AGE: Years: 89 Months: 5 Days: 5 If less than one day: hrs. min.

9. Birthplace: Eckhart Allegany, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: George Williamson

13. Birthplace: Scotland

MOTHER — 14. Maiden name: Isabella Oliver

15. Birthplace: Scotland

16. Informant: Oliver Simons

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 7-1945 (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: Eckhart Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. 3-6 1945 (Date rec'd by registrar) Mrs Stanley A. Rae Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 5 1945, at 4 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 19..., to Mar 5 1945 and that I last saw her alive on Mar 2 1945

	DURATION
Immediate cause of death: Senility	
Due to: Cerebral Sclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. O. Lane M.D.

Address: Frostburg Md. M. D. or other

Date signed: Mar 5 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02478

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 819 Patterson Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Walter L. Simpson

3. (b) Social Security Number 217-10-6783

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Bettie Iser

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 22 1909

8. AGE: Years	Months	Days	If less than one day
36	1	11	..... hrs. ..... min.

9. Birthplace Rose Hill W. Va.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business K. S. Tire Co.

FATHER 12. Name Charles L. Simpson

FATHER 13. Birthplace W. Va.

MOTHER 14. Maiden name Ida A. Anderson

MOTHER 15. Birthplace W. Va.

16. Informant Mrs. Bettie Simpson

Address Cumberland

17. Burial Date thereof Mar 5 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Mar 5 19 45 Walter R. Wantz M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3 1945, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26 1945 to Mch 3 1945 and that I last saw him alive on Mch 3 1945

Immediate cause of death	DURATION
Cerebro-Spinal Meningitis	
Due to Streptococcic type	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. D. Weaver M.D. M.D. or other

Address 49 Greene St Date signed 3-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

02479 10

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank Sowerby

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha Sowerby

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): September 30 1880

8. AGE:

Years	Months	Days	If less than one day
64	5	17	..... hrs. ..... min.

9. Birthplace: Keswick Ontario, Canada

(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Railroad

FATHER 12. Name: John Sowerby

13. Birthplace: Canada

MOTHER 14. Maiden name: Mary Etta Bennett

15. Birthplace: Canada

16. Informant: Mary Sowerby

Address: Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland Md

18. Funeral director: J. J. Derst

Address: Frostburg Md.

19. March 21 19 45 (Date rec'd by registrar) Veronica McDermott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 19 45 at 8.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941 19..... to March 20 19 45

and that I last saw h... alive on March 19 19 45

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension heart disease	6 weeks and years
Due to:	
Other conditions: 2 Hemiplegia	and years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Allen G. Murray M.D. M. D. or other

Address: Cumberland Md. Date signed: March 21 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85-d)

02480

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart Mines

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred:

Eckhart Mines, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eckhart Mines Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Loretta Sullivan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13 - 1870

8. AGE: Years 75 | Months 0 | Days 18 | If less than one day hrs. min.

9. Birthplace Eckhart Allegany, Md.
(Town, County, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name William Sullivan

13. Birthplace Ireland

MOTHER 14. Maiden name Johanna Murphy

15. Birthplace Ireland

16. Informant Mary Feldman

Address Eckhart Mines, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Cyan. 3-1945 (month) (day) (year)

Cemetery or crematory St. Michael's Cemetery

Location Frostburg

18. Funeral director Jacob Wafer

Address Frostburg, Md.

19. 4-2 1945 (Date rec'd by registrar) Thos. Davey H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 31 1945, at 11.04 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 22 1944, to Mar 31 1945, and that I last saw her alive on Mar 30 1945

	DURATION
Immediate cause of death: Hypertension	? ?
Due to: Arterio Sclerosis	? ?
Due to: Hemiplegia	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. McLane Jr. M.D. M. D. or other

Address Frostburg Md Date signed 4-2-45

(M)

MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

02481

CERTIFICATE OF DEATH

Reg. Diat. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: Rural near McCoole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W.Va. County: Mineral
City or town: Rural near Keyser
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R#3
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Jerry Taylor (Jeremiah Taylor)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Carrie Elizabeth Taylor
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1872

8. AGE: Years	Months	Days	If less than one day
72	5	15	..... hrs. ..... min.

9. Birthplace: Gettysburg, Pa.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: William Taylor
13. Birthplace: Pa.

MOTHER
14. Maiden name: Elizabeth Baker
15. Birthplace: Pa.

16. Informant: Robert Taylor
Address: R#3 Keyser, W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 28-45 (month) (day) (year)
Cemetery or crematory: Dayton Cemetery
Location: near 21st. Bridge, Md.

18. Funeral director: N.L.Rogers Funeral Directors
Address: Keyser, W.Va.

19. Mar. 28 19 45 (Date rec'd by registrar) Kaylin Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25th., 19 45, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op. .....
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Prince H. Brown M.D. M. D. or other
Address: Cumberland, Maryland Date signed: 3-25-45

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-al

02482

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 88 yrs.

Hospital, institution, or street address where death occurred: 119 Polk St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 119 Polk St.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Clara L. Wickard.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): 1856

8. AGE: Years: 88 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home.

FATHER — 12. Name: Jacob Wickard

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Jane Carleton

MOTHER — 15. Birthplace: Md.

16. Informant: Chas H Wickard

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 22 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland.

18. Funeral director: Louis Stein & Son

Address: Cumberland.

19. Mar 22, 1945 (Date rec'd by registrar) Walter L. Trautz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20 1945 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1945, to March 20, 1945, and that I last saw her alive on March 20, 1945.

	DURATION
Immediate cause of death: Pneumonia - Bronchial	3 days
Due to: Influenza, Co.	5 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: C. F. U. Lauder M. D. or other

Address: Cumberland Md. Date signed: 3-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

02483

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution, or street address where death occurred:
716 Park St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 716 Park St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Owen Wilson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Ella North
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 21 1864

8. AGE: Years	Months	Days	If less than one day
80	5	19	hrs. min.

9. Birthplace Enoch's Branch, Ind (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Retired
12. Name of father Jesse Wilson
13. Birthplace of father Ind.
14. Maiden name of mother Sara Stewart
15. Birthplace of mother Ind.
16. Informant Clay Wilson
Address Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13 45 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Louis Stein, Inc
Address Cumberland
19. March 13, 19 45 Walter F. Franty, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 19 45 at 6 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/19 19 45 to 3-10-45 19 45
and that I last saw him alive on 3-8- 19 45

	DURATION
Immediate cause of death Cardiac Failure	
Due to Myocarditis (?)	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 3-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02484 Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? — 40 yrs
Hospital, institution, or street address where death occurred:
Potomac Edison Company Carbern
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 117 Seymour St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Walter Bryan Wilson

3.(b) Social Security Number: 214-05-4859

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances M Wilson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 5 1900

8. AGE: Years	Months	Days	If less than one day
44	8	29	hrs. min.

9. Birthplace: Pa (Town, county, and state)
10. Usual occupation: Transfer
11. Industry or business: Potomac Edison Co.
FATHER 12. Name: Wm E. Wilson
13. Birthplace: Pa
MOTHER 14. Maiden name: Martha Brannan
15. Birthplace: Pa
16. Informant: Mrs Frances M Wilson
Address: Cumberland Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof: May 6 1945 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Largent W. Va
18. Funeral director: Louis Dean Sons
Address: Cumberland Md
19. March 6 1945 (Date rec'd by registrar) Walter R Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4th., 1945 at 5.30A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op.
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Prince H. Brown M.D. M. D. or other
Address: Cumberland, Maryland Date signed: 3-4-45

Deputy Medical Examiner : Allegany Co

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

02485

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Vale Summit
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 23 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Vale Summit Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME: David Yates

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife: Margaret Stevens
6(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): April 23 1883

8. AGE:

Years	Months	Days	If less than one day
61	10	12	____ hrs. ____ min.

9. Birthplace: National Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Coal Miner (Retired)
11. Industry or business: Consolidation Coal Co.

FATHER
12. Name: David Yates
13. Birthplace: Jiklsman, Md

MOTHER
14. Maiden name: Mary Carter
15. Birthplace: Eckhart, Md.

16. Informant: Mr. Chester Yates
Address: Vale Summit, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 7, 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md.
18. Funeral director: W. E. Richbourg
Address: Lonaconing, Md

19. March 7 19 45 D. S. Offutt
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5, 1945, at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 27, 1945, to Mar 5, 1945 and that I last saw h— alive on Mar 4, 1945.

Immediate cause of death: Bronchial Asthma
Due to: Acute Cardiac Dilatation
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)

DURATION
several years
1 Day

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: W. D. McLaughlin M.D.
M. D. or other
Address: Frostburg Md Date signed: Mar 6 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A16

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

02486

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 yrs.
Hospital, Institution, or street address where death occurred:
176 S. Allegany St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 176 S. Allegany St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Imay Young

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Samuel D. Young.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 3, 1854

8. AGE: Years	Months	Days	If less than one day
90	10	10	..... hrs. ..... min.

9. Birthplace Lynchburg Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At Home.
FATHER 12. Name Orrin Canfield
13. Birthplace Va.
MOTHER 14. Maiden name — Powell
15. Birthplace Va.
16. Informant Mrs. Wm. B. Kelley,
Address Cumberland
17. Burial Date thereof May 16 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Peter & Paul's Cem
Location Cumberland
18. Funeral director Lewis Stein Inc
Address Cumberland
19. March 16, 1945 Winter R. Tranty, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945 at 9 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 1945 to Mar 13 1945
and that I last saw her alive on Mar 10 1945

Immediate cause of death	DURATION
Chronic Myocarditis	2 yrs
Due to	
Due to	
Other conditions Arteriosclerosis	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. A. Trewaskis, M.D.
M. D. or other
Address Cumberland, Md Date signed 3/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137a)

CERTIFICATE OF DEATH

02487

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 62 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: ~~CUMBERLAND~~ McCoole
(If outside city or town limits, write RURAL and give nearest town)
Street No. (RT. #3, KEYSER, W.VA.)
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MRS. MILDRED YOUNGBLOOD

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: ROBERT YOUNGBLOOD
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): August 28, 1918

8. AGE: Years	Months	Days	If less than one day
26	6	7	hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: HWFE.
11. Industry or business

FATHER
12. Name: BENJAMIN MILLER
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: alice Miller
15. Birthplace: MARYLAND

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 7 (45) (month) (day) (year)
Cemetery or crematory: Miller Cemetery
Location: 3 Mi E of Westernport
18. Funeral director: E Gudeth & Bro
Address: Westernport, Md.

19. Mar 7, 1945 (Date rec'd by registrar) Winter R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAR. 5, 1945 10:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 9, 1945 to MAR. 5, 1945 and that I last saw her alive on MAR. 5, 1945

	DURATION
Immediate cause of death: Septicaemia	
Due to: Pelvic Inflammation	
Due to: 3 months post partum	
Due to: Sutured. Drained	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Pelvic abscess
Date of op. 2-20-45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. M. Wilson M.D. M. D. or other
Address: Cumberland Md Date signed 3-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

S. Brings

02488 4

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital Cumberland, Md

How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For unborn infants give residence of mother)

State Maryland County Garrett

City or town Mt Lake Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George E Zimmermann

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Alice Zimmerman

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) April 25, 1862

8. AGE: Years	Months	Days	If less than one day
82	10	29	...hrs. ...min.

9. Birthplace Somerset Co. Scottdale Pa.

(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name John Zimmerman

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Anna E. Russell

15. Birthplace Springfield, Pa.

16. Informant Roy Zimmerman

Address Mt Lake Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 20-1945 (month) (day) (year)

Cemetery or crematory Ferndale Md

Location Mar. Oakland Md

18. Funeral director Emroy Bolden

Address Oakland Md

19. Mar 22, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/17 1945, at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16 1945 to March 17 1945

and that I last saw h... alive on March 17 1945

Immediate cause of death	DURATION
pulmonary embolism	2 hours
Due to phlebitis	2 days
Due to fractured neck of the femur	4 weeks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? fell down and suffered fracture Date of 2-16-45

Where did injury occur? home at Mt Lake Park (City or town) Garrett County (State) Md

Injured at home, farm, industry, public place (where?)

Means of injury slipped and fell Injured at work? no

23. SIGNATURE L Brings MD M. D. or other

Address Lonaconing Md Date signed 3-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (139-2)

CERTIFICATE OF DEATH

02489

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGHENY CO.
City or town CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 Years.
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 5 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGHENY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 BOONE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MRS. FLORA M. ZOMBRO

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife JOHN ZOMBRO
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) FEB 2 1873

8. AGE: Years	Months	Days	If less than one day
72	1	14	..... hrs. ..... min.

9. Birthplace W. VIRGINIA
(Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name JOSEPH S. MOORE
13. Birthplace W. VA.

MOTHER
14. Maiden name MARY CRITTON
15. Birthplace W. VA.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MARYLAND

17. Burial Date thereof 3/18/45
(Burial, cremation, or removal. Which?) (mooth) (day) (year)
Cemetery or crematory Hill Crest Cemetery
Location Cumberland, Md.
18. Funeral director William H. Kight
Address Cumberland, Md.

19. Mar. 17, 1945 Winter R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1945, to March 16 1945
and that I last saw h.. alive on March 15 1945.

	DURATION
Immediate cause of death	
Coma	1 day
Due to diabetes mellitus	?
Due to gangrene toes 3-22-45	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Prof. of uterus
Proposed operation Date of op. 3-22-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE E. M. Wilson M.D. M. D. or other
Address Cumberland Md. Date signed 3-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15